Supreme Court, U.S.
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No. 02-

IN THE

Supreme Court of the United States

BRIAN MARTIN, Individually and as the Administrator of the Estate of Norma Martin, deceased,

Petitioner,

v.

ARKANSAS BLUE CROSS AND BLUE SHIELD, a Mutual Insurance Company,

Respondent.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

PETITION FOR A WRIT OF CERTIORARI

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QUESTION PRESENTED

In some jurisdictions ERISA participants who have been wrongfully denied medical benefits and are the prevailing party in a lawsuit are not given the presumption of awarding attorney fees. In other circuits the presumption is still adhered to, while in other circuits they have adopted a test where they apply factors to be weighed. In the circumstances where an ERISA participant is not awarded attorney fees they face the grim situation of having to find the compensation for their counsel. This can be very difficult due to the fact that the award they have just received from the suit is not a monetary award. The fact that there is no unified standard for awarding attorney fees to a prevailing plaintiff in an ERISA case makes it difficult for a party seeking representation to asses whether they have ample means for adequate representation. Without the means of seeking adequate representation the judicial system is lacking in one of its most important roles, that of due process.

The question presented is whether there should be a presumption of awarding attorney fees to the prevailing plaintiff in ERISA cases involving the wrongful denial of medically necessary treatment?

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Appendix B — Judgment And Memorandum Opinion Of The United States District Court For The Western District Of Arkansas, Fayetteville Division Dated And Filed June 6, 2000 ..... 16a

Plaintiff respectfully prays that a writ of certiorari issue to review the judgment and opinion of the United States Court of Appeals for the Eighth Circuit, which affirmed the decision of the district court, on August 16, 2002, so that this Court might resolve the issue of whether there should be a presumption of awarding attorney fees in ERISA cases. There is a compelling reasons for review: the strong Congressional desire for national uniformity in enacting the Employee Retirement Income Security Act (ERISA), a goal often expressed by this Court in ERISA decisions.

OPINIONS BELOW

The opinion of the United States Court of Appeals for the Eighth Circuit, rendered August 16, 2002, is reported at 299 F.3d 966 (8th Cir. 2002), and is reprinted in the appendix hereto as Appendix A at 1a. The order of the United States District Court for the Western District of Arkansas, issued September 5, 2000 is reprinted in Appendix B at 16a.

JURISDICTIONAL STATEMENT

The district court had jurisdiction of this action pursuant to 28 U.S.C. § 1331 as applying the Employee Retirement Income Security Act of 1971 ("ERISA"), 29 U.S.C. § 1001, *et seq.*, pre-empts all state law claims and presents a federal question. The district court denied the plaintiff/petitioner's motion for attorney's fees.

An appeal was taken to the Eighth Circuit Court of Appeals pursuant to 28 U.S.C. § 1291. The judgment of the court of appeals was entered August 16, 2002.

The Jurisdiction of this court is invoked pursuant to 28 U.S.C. § 1254.

STATUTE INVOLVED

The Employee Retirement Income Security Act of 1974 ("ERISA") 29 U.S.C. § 1132(g)(1) provide:

> § 1132(g) Attorney's fees and costs; awards in actions involving delinquent contributions
>
> (g)(1) In any action under this subchapter (other than an action described in paragraph (2)) by a participant, beneficiary, or fiduciary, the court in its discretion may allow a reasonable attorney's fee and costs of action to either party.

STATEMENT OF THE CASE

The petitioner Norma Martin was an employee of Washington Regional Medical Center and as an employee of Washington Regional Medical Center was insured by an Arkansas BlueCross BlueShield welfare benefit plan. By virtue of Norma Martin's employment by Washington County Regional Medical Center, Norma Martin was a subscriber of and entitled to medical care under the plan. The plan provided coverage for all medically necessary medical and hospital services. Norma Martin was diagnosed as suffering from recurrent bronchoalveolar cell carcinoma (BAC) of the lung. Norma Martin's physician, Irvin Paradis, M.D. recommended that she have a lung transplant. All of Norma Martin's treating physicians agreed the transplant would be advantageous and that Norma Martin was in a desperate battle for her life. Arkansas BlueCross BlueShield was notified of the recommendation that Norma Martin have a lung transplant. Arkansas BlueCross BlueShield denied coverage based on the experimental/investigational exclusion

of the plan. The District Court found against Arkansas BlueCross BlueShield and ordered it to provide for the lung transplant. BlueCross BlueShield did not appeal and subsequently provided the lung transplant, however the court refused to award the plaintiff any attorney fees, primarily because Blue Cross and Blue Shield elected not to appeal.

REASONS FOR GRANTING THE PETITION

There is a split in the circuits that threatens the uniformity of the provisions set forth in ERISA cases that allows the court to award attorney fees to the prevailing party and that could have an adverse affect for an ERISA participant who seeks non-monetary benefits

This case is compelling for review and resolution by this Court. In an ERISA case involving a health benefit plan, a prevailing plaintiff obtains no monetary recovery; only the health benefits providers receive monies. Contingency agreements would be meaningless. Fee shifting is the only means for a plaintiff's attorney to be paid. A participant in need of treatment cannot obtain the ready access Congress intended, 29 U.S.C. § 1001(b).

The circuits that have addressed the issue have an irreconcilable split in their decisions regarding a presumption that the prevailing party be awarded attorney fees in ERISA cases. The First, Third, Fourth, Fifth, Sixth, Eleventh, and D.C. circuits have all rejected the presumption of the prevailing plan participant. *Eddy v. Colonial Life Ins. Co. of Am.*, 59 F.3d 201 (D.C. Cir. 1995); *Cottrill v. Sparrow, Johnson & Ursillo, Inc.*, 100 F.3d 220 (1st Cir. 1996); *Ellison v. Shenango Inc. Pension Bd.*, 956 F.2d 1268 (3d Cir. 1992); *Quesinberry v. Life Ins. Co. of N. Am.*, 987 F.2d 1017

(4th Cir. 1993); *Iron Workers Local No. 272 v. Bowen*, 624 F.2d 1255 (5th Cir. 1980); *Foltice v. Guardsman Products, Inc.*, 98 F.3d 933 (6th Cir. 1996); *Wright v. Hanna Steel Corp.*, 270 F.3d 1336 (11th Cir. 2001). The Eight Circuit also rejected it in the present case. *Martin v. Blue Cross and Blue Shield*, 299 F.3d 966 (8th Cir. 2002). The Seventh and Ninth circuits still adhere to a presumption, but also apply a five-factor test. *McElwaine v. US West, Inc.*, 176 F.3d 1167 (9th Cir. 1999); *Central States, Southeast and Southwest Areas Pension Fund v. Hunt Truck Lines*, 272 F.3d 1000 (7th Cir. 2001). The Second and Tenth circuits have not rejected the presumption. *Chambless v. Masters, Mates & Pilots Pension Plan*, 815 F.2d 869 (2d Cir. 1987); *Gordon v. United States Steel Corp.*, 724 F.2d 106 (10th Cir. 1983).

The courts that reject the presumption in favor of fees have adopted a somewhat varied five-factor test. The five factors are set out in *Lawrence v. Westerhaus*, 749 F.2d 494 (8th Cir. 1984).[1] The current decision makes the factors less certain. In the instant case the court reasoned that the ERISA statute is closely similar to the Copyright Acts fee-shifting provision, 17 U.S.C. § 505. There is no unitary standard that applies to prevailing parties in copyright suits, but there are factors to guide determination that the Eighth Circuit seemingly would not apply. Compare with *Gonzales v. Transfer Technologies, Inc.*, 301 F.3d 608 (7th Cir. 2002).

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1. The five factors are: (1) the degree of the opposing parties culpability or bad faith; (2) the ability of the opposing parties to satisfy an award of attorney's fees; (3) whether an award of attorney's fees against the opposing parties could deter other persons acting under similar circumstances; (4) whether the parties requesting attorney's fees sought to benefit all participants and beneficiaries of an ERISA plan or to resolve a significant legal question regarding ERISA itself; (5) the relative merits of the parties' positions.

A factor the *Gonzales* court considered was the advance consideration of compensation and deterrence. *Id.* It would not be sufficient that the wrongdoer said he would not appeal, as happened in the instant case, Judge Posner likened such conduct to a criminal saying he would not appeal a criminal conviction, while the Eighth circuit thought such conduct sufficiently commendable to affirm the district court relieving the wrongdoer from paying fees.

The Copyright Act as well as the ERISA statute, so the Eighth Circuit now says, were created to protect economic rights. The infringement in *Gonzales* was willful, and willful infringement usually involves small amounts of money, and the infringements cannot be deterred without an award of attorney fees. *Id.* at 610. If attorney fees are not allowed in these types of cases this would allow minor infringements, that are willful, to be in effect privileged and immune from legal address. *Id.* at 610. Just as a willful copyright infringement deserves deterrence so to does an abuse that an ERISA participant receives when being denied a valid claim that has no monetary value. This is especially true in a claim for non-monetary relief as in Norma Martin's claim for a lung transplant. The fact that Congress recognizes the need to deter certain activities of defendants under ERISA provisions illustrates the importance of awarding attorney fees in statutes that protect economic interests even absent the requirements of the prevailing party statutes. The protection should be afforded to ERISA participants who are being unfairly denied benefits by insurance companies before adjudication.

The result of a fee-shifting statute is to enable a party denied benefits with no other compensation to hire competent counsel to represent them. Statutes that do not mandate an

award of attorney fees to the prevailing party already exert a deterrent effect on attorneys pursuing ERISA cases. This especially will be seen in cases where the relief sought is not monetary relief. In these types of cases there is no monetary award available to the prevailing plaintiff to compensate her attorney. This will have the effect of numerous competent attorneys declining to represent ERISA participants and result in a wrong without a remedy. It will effectively deny access to the courtroom for those who can least afford to pay. If a party does not have access to effective legal counsel the judicial system has failed its purpose in the due process system.

In considering whether a fee-shifting presumption should apply to prevailing ERISA plaintiffs the court should look at other similar statutes that require a prevailing plaintiff to be awarded attorney fees. The Equal Access to Justice Act (EAJA) has been interpreted to provide that a court shall award to a prevailing party . . . fees . . . unless the court finds that the position of the United States was substantially justified or that special circumstances make an award unjust. *Perez-Arellano v. Smith*, 279 F.3d 791 (9th Cir. 2002). Quoting 28 U.S.C. § 2412(d). The fee-shifting statutes that create a presumption clearly demonstrate the goals Congress intended them to have, one for deterrence and just compensation for the prevailing plaintiff and counsel, and another for unified access to the courtroom. Only by way of a presumption can "ready access" be achieved. The question and differences amongst the courts of appeal merit resolution by this court at a time where there is a health care crisis as it is in our national delivery system as witnessed in earlier decisions by this court.

CONCLUSION

For the foregoing reasons, the petition for writ of certiorari should be granted.

Respectfully submitted,

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APPENDIX A — OPINION OF THE UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT DATED AND FILED AUGUST 16, 2002

UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

No. 00-3420

Brian Martin, Individually and as the Administrator of the Estate of Norma Martin, deceased,

Appellant,

v.

Arkansas Blue Cross and Blue Shield, a Mutual Insurance Company,

Appellee.

Appeal from the United States District Court for the Eastern District of Arkansas

Submitted: January 15, 2002

Filed: August 16, 2002

Appendix A

Before WOLLMAN,[1] Chief Judge, McMILLIAN, BOWMAN, BEAM, LOKEN, HANSEN,[2] MORRIS SHEPPARD ARNOLD, MURPHY, BYE, and RILEY, Circuit Judges.

BEAM, Circuit Judge.

Brian Martin appeals the district court's denial of attorney fees in this case under the Employee Retirement Income Security Act (ERISA), 29 U.S.C. § 1001 *et seq.* We affirm.

I. BACKGROUND

Norma Martin asked Arkansas Blue Cross and Blue Shield (the Plan) to certify benefits for a lung transplant pursuant to an ERISA employee welfare benefit plan in which she participated. After the Plan denied benefits, Martin sued, alleging that benefits had been wrongfully denied.

The district court held that a procedural irregularity rendered the Plan's denial unreasonable and ordered the Plan to certify coverage for the lung transplant. Martin then petitioned for attorney fees, and asked for a contingent fee based on the cost of the lung transplant surgery (one-third of $125,000, or $41,666.67). The district court denied the

1. The Honorable Roger L. Wollman stepped down as Chief Judge of the United States Court of Appeals for the Eighth Circuit at the close of business on January 31, 2002. He has been succeeded by the Honorable David R. Hansen.

2. The Honorable David R. Hansen became Chief Judge of the United States Court of Appeals for the Eighth Circuit on February 1, 2002.

petition for fees. The district court applied the five-factor test set forth in *Lawrence v. Westerhaus*, 749 F.2d 494, 495-96 (8th Cir. 1984), and determined that the factors weighed in favor of the Plan. The district court acknowledged the *Landro v. Glendenning Motorways, Inc.*, 625 F.2d 1344, 1356 (8th Cir. 1980), presumption in favor of awarding fees absent special circumstances, and concluded that "consideration of the *Lawrence* factors leads the Court to believe that plaintiffs are not entitled to shift their attorneys' fee onto the shoulders of defendant in this matter." The district court also denied the fee petition on the alternative ground that Martin had not offered evidence concerning the number of hours reasonably spent on the litigation, or the reasonable hourly rate for such services, holding that a contingent fee award was inappropriate in an ERISA case. Martin filed a motion for reconsideration, setting forth an hourly fee request in the amount of $11,091. Martin brought this appeal after the district court denied the motion for reconsideration.[3]

II. DISCUSSION

ERISA's fee-shifting provision unambiguously gives the district court discretion to award attorney fees to "either party." 29 U.S.C. § 1132(g). In making this determination, a district court abuses its discretion when there is a lack of factual support for its decision, or when it fails to follow applicable law. *Richards v. Aramark Servs., Inc.*, 108 F.3d 925, 927 (8th Cir. 1997).

3. At oral argument, Martin's counsel clarified that he no longer seeks a contingency fee, but simply appeals the denial of the fee requested on reconsideration.

Appendix A

This case involves the conundrum of what, exactly, is the applicable law for ERISA attorney fee applications in this circuit. On one hand, our circuit was one of the first to apply the presumption in favor of prevailing ERISA plaintiffs. In *Landro*, we held that the prevailing plaintiff was entitled to a presumption in favor of a fee award—limited by the losing defendant's ability to show special circumstances in support of denying an award. 625 F.2d at 1356. We noted that the losing defendant had the burden of proving those special circumstances. *Id.* at 1356 n.19. Then, in *Westerhaus*, 749 F.2d at 496, we identified a five-factor test[4] designed to aid the district court in making its discretionary determination regarding fees, but failed to mention the presumption. *See also Jacobs v. Pickands Mather & Co.*, 933 F.2d 652, 659 (8th Cir. 1991) (stating that court should consider the enumerated *Westerhaus* factors in exercising its discretion concerning whether to award attorney fees).

Lutheran Medical Center v. Contractors, Laborers, Teamsters and Engineers Health and Welfare Plan, 25 F.3d 616, 623-24 (8th Cir. 1994) appears to be the first case in

4. Those factors are: (1) the degree of culpability or bad faith of the opposing party; (2) the ability of the opposing party to pay attorney fees; (3) whether an award of attorney fees against the opposing party might have a future deterrent effect under similar circumstances; (4) whether the parties requesting attorney fees sought to benefit all participants and beneficiaries of a plan or to resolve a significant legal question regarding ERISA itself; and (5) the relative merits of the parties' positions. *Westerhaus*, 749 F.2d at 496. The *Westerhaus* court quoted these factors from the Fifth Circuit's opinion in *Iron Workers Local No. 272 v. Bowen*, 624 F.2d 1255, 1266 (5th Cir.1980).

which we referred to the five-factor test and the presumption in the same analysis. In *Lutheran Medical* we affirmed the district court's decision to award fees to the plaintiff, and noted that "the Plan has not shown any special circumstances. Moreover, the district court exhaustively considered all five factors set forth in *Jacobs*." *Id.* at 624. Also, in affirming the district court's award of attorney fees in *Stanton v. Larry Fowler Trucking, Inc.*, 52 F.3d 723, 730 (8th Cir. 1995), we noted that the defendant bore the burden of showing special circumstances to preclude an attorney fees award, and credited the district court's consideration of the five-factor test in its decision to award fees to the plaintiff. *Id.* at 729-30. *See also Milone v. Exclusive Healthcare, Inc.*, 244 F.3d 615, 620 (8th Cir. 2001) (referring to both the presumption and five-factor test).

A review of our sister circuits indicates that the First, Third, Fourth, Fifth, Sixth, Eleventh,[5] and D.C. circuits have all considered the presumption and expressly rejected its application. *E.g.*, *Cottrill v. Sparrow, Johnson & Ursillo, Inc.*, 100 F.3d 220, 226 (1st Cir. 1996); *Eddy v. Colonial Life Ins. Co. of Am.*, 59 F.3d 201, 205-06 (D.C.Cir. 1995); *Quesinberry v. Life Ins. Co. of N.Am.*, 987 F.2d 1017, 1030 (4th Cir. 1993); *Ellison v. Shenango Inc. Pension Bd.*, 956 F.2d 1268, 1274

5. While the Eleventh Circuit has not considered and rejected the presumption, the Fifth Circuit case that did, *Bowen*, 624 F.2d 1255, was decided in 1980 before the Eleventh Circuit was created by splitting apart the Fifth Circuit, and thus is considered binding precedent on the Eleventh Circuit. *See Bonner v. City of Prichard*, 661 F.2d 1206, 1209 (11th Cir.1981) (en banc) (Eleventh Circuit adopted as binding precedent all decisions of the former Fifth Circuit handed down prior to October 1, 1981).

(3d Cir. 1992); *Armistead v. Vernitron Corp.*, 944 F.2d 1287, 1302 (6th Cir. 1991); *Iron Workers Local No. 272 v. Bowen*, 624 F.2d 1255, 1266 (5th Cir. 1980).

The Second and Tenth circuits do not use the presumption, but have not considered and expressly rejected it. *E.g.*, *Chambless v. Masters, Mates & Pilots Pension Plan*, 815 F.2d 869, 871 (2d Cir. 1987); *Gordon v. United States Steel Corp.*, 724 F.2d 106, 109 (10th Cir. 1983).[6] In fact, the Tenth Circuit is the genesis of the five-factor test, as first enunciated in *Eaves v. Penn*, 587 F.2d 453, 465 (10th Cir. 1978).

Finally, the Seventh and Ninth Circuits appear to utilize some version of both the five-factor test and a presumption in conducting the discretionary attorney fee analysis. *See McElwaine v. U.S. West, Inc.*, 176 F.3d 1167, 1172 (9th Cir. 1999) (spelling out the five-factor test and stating that court should also apply the special circumstances rule); *Little v. Cox's Supermarkets*, 71 F.3d 637, 644 (7th Cir. 1995) (noting that courts can use either the five-factor test or a "modest presumption" and that under either formulation, "the 'bottom-line question' is the same: was the losing party's position substantially justified and taken in good faith, or was that party simply out to harass its opponent").

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6. An unpublished per curiam opinion from the Tenth Circuit does cite *Landro* and refers to the presumption. *See Jenkins v. Green Bay Packaging, Inc.*, No. 93-5038, 1994 WL 609387, at *2 (10th Cir. Nov. 7, 1994). However, because it is unpublished, that case is not considered precedent in the Tenth Circuit, *see* Tenth Cir. R. 36.3(A), and no other Tenth Circuit case mentions the presumption.

In the cases that expressly rejected the presumption, the proponent of the presumption generally analogized the ERISA fee-shifting structure to the similar fee-shifting statute in civil rights cases, citing particularly to *Hensley v. Eckerhart*, 461 U.S. 424 (1983). *Hensley* clarified the standards for attorney fees in civil rights cases, and the Court noted that prevailing plaintiffs may ordinarily recover attorney fees unless special circumstances make an award unjust. *Id.* at 429 (citing *Newman v. Piggie Park Enters., Inc.*, 390 U.S. 400, 402 (1968) (per curiam)). The cases rejecting the *Newman* and *Hensley* approach in ERISA cases reason that despite similar language in the civil rights fee-shifting statutes and ERISA's fee-shifting provision,[7] the overall aims of the civil rights statutes are quite different from ERISA's purpose. *E.g.*, *Eddy*, 59 F.3d at 204-05. ERISA protects statutorily-created economic interests, while the civil rights statutes protect constitutionally-based dignitary and individual economic interests, which are uniquely important to our nation as a whole. *Id.* The *Eddy* court also reasoned that it would belittle the stature accorded civil rights cases to apply the fee-shifting presumption in other types of cases. *Id.* at 205. And, while the legislative history of the civil rights statutes indicated a presumption is warranted in those case, ERISA lacks similar legislative history. *Id.*

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7. Though the statutes are similar, there is a fundamental difference between the civil rights fee-shifting statute, which provides for attorney fees to the "prevailing party," 42 U.S.C. §§ 1988(b) & 2000e-5(k), and the ERISA statute, which allows the district court to award fees to "either party," 29 U.S.C. § 1132(g)(1).

We agree with the reasoning in *Eddy* and find that ERISA does not closely correspond with the fee-shifting scheme in the civil rights statutes. Instead, ERISA's language is neutral in its reference to fees, similar to the statute construed by the Supreme Court in *Fogerty v. Fantasy, Inc.*, 510 U.S. 517, 533 (1994). In *Fogerty*, the Court considered whether the Copyright Act's fee-shifting provision, 17 U.S.C. § 505, was analogous to the civil rights fee-shifting statutes. 510 U.S. at 522. The plaintiff in *Fogerty* asserted there should be a dual standard (treating prevailing plaintiffs more favorably) for Copyright Act fee determinations as established in *Christiansburg Garment Co. v. EEOC*, 434 U.S. 412, 421 (1978), for Title VII cases. The Court rejected this analogy, despite similar language in the statutes. 510 U.S. at 523-25. The Court credited the "important policy objectives of the Civil Rights statutes," and noted that these objectives were absent in a case involving the Copyright Act. *Id.* at 523.

Like the Copyright Act as construed in *Fogerty*, ERISA involves vindication of statutory, economic rights. Also like the Copyright Act, and as admitted by counsel at argument, there is a dearth of legislative history on ERISA, and certainly none which suggests that it was enacted to further important societal goals or " 'polic[ies] that Congress considered of the highest priority.' " *Id.* (*quoting Christiansburg*, 434 U.S. at 418, *quoting Piggie Park*, 390 U.S. at 402.). Instead, both the Copyright Act and ERISA have neutral, discretionary attorney fee language, and equally neutral (or sparse) legislative history concerning attorney fees.

Finally, the "American Rule" that each party normally bears the cost of the litigation unless Congress provides otherwise, *Fogerty*, 510 U.S. at 533, pervades our analysis. While Congress did provide for fee shifting at the district court's discretion in ERISA cases, the operation of a presumption in favor of fees undermines the "American Rule" and should be employed only in extraordinary cases, such as civil rights litigation. In *Fogerty*, the Court noted that Congress "legislates against the strong background of the American Rule" and pointed out that the fee-shifting statute's use of the word" 'may' clearly connotes discretion. The automatic awarding of attorney's fees to the prevailing party would pretermit the exercise of that discretion." *Id.* The Court rejected the argument that Congress's modification of the American Rule by providing for fees in the Copyright Act meant that it intended to adopt the "British Rule" that the prevailing party be awarded attorney fees as a matter of course, absent exceptional circumstances. The Court stated, "[s]uch a bold departure from traditional practice would have surely drawn more explicit statutory language and legislative comment." *Id.* at 534.

For all of these reasons, we agree with the overwhelming majority of circuits that have considered this issue and concluded that the presumption should not be employed in ERISA cases. Although our circuit was the first to apply the presumption in ERISA fee-shifting cases, we now find that use of several non-exclusive factors best facilitates the exercise of the district court's discretion in ERISA cases. We overrule *Landro*'s holding to the contrary. However, we caution that the "five factors" set forth by *Westerhaus* are by no means exclusive or to be mechanically applied.

The *Eddy* court noted that a mechanical application of the factors may serve to undermine "both the substantive purpose of ERISA and the discretion vested in the courts to carry out that purpose." 59 F.3d at 207. Instead, the district courts should use the factors and other relevant considerations as general guidelines for determining when a fee is appropriate.

For instance, when considering "ability to pay," the district court should keep in mind fundamental differences in plan funding mechanisms. Ordering large fee payments from an employee-funded plan might actually hurt the plan participants by increasing costs, contrary to the statutory purpose of ERISA. Martin advances the argument that the district court should consider the "results obtained" when determining whether to award fees, and, in that analysis, consider the *kind* of results obtained. According to Martin, if the benefits awarded are non-monetary in nature—as here where the benefit awarded was a *lung*—the district court should deem this especially important because the participant is not receiving a pool of money from which fees can be paid. While it is true that the district court may consider this information, because it may consider any and all facts it deems relevant, to the extent that this particular factor is truly a "result obtained," it is more prudently considered when determining the *amount* of the judgment, once the district court has already decided a fee should be awarded. *Cf. Hensley*, 461 U.S. at 429 & 430 n.3 (once it decides a fee should be awarded, the district court may take into consideration all of the usual factors a court considers when determining the amount of a fee, including the "results obtained" and the "novelty and difficulty of the questions"). *See also Fogerty*, 510 U.S. at 534 n.19 (expressly condoning

the use of "several nonexclusive factors that courts should consider in making awards of attorney's fees to any prevailing party. . . . so long as such factors are faithful to the purposes" of the act in question).

The bottom line is, district courts are not obligated to regurgitate, rote, the *Westerhaus* factors. They are well-recognized *general guidelines* which provide direction to the district court, while also facilitating "meaningful appellate review." *Eddy*, 59 F.3d at 206. As the *Eddy* court noted, "[w]hile a particular application of the . . . factors may be subject to criticism, the factors are reasonable and have been widely accepted by the courts." *Id.* Indeed, Martin admitted at oral argument that few, if any, fee awards have been denied a prevailing plaintiff in ERISA cases nationwide. This is true even though nine of the circuit courts of appeals do not employ any kind of presumption in favor of fees. Thus, the absence of a presumption has obviously not doomed ERISA plaintiffs' attorney fee requests, and will not do so in this circuit either.

The district court used the factors *and* considered the presumption, but it is clear that the court's analysis of factors in deciding not to award a fee to Martin comports with our holding today. The court cited *Landro* and its presumption but then analyzed the Plan's actions according to the following factors: the Plan fully cooperated by expediting the exhaustion of plan administrative remedies, by presenting a stipulated record to the district court, by agreeing to a simultaneous briefing schedule, and finally, by not appealing the district court's adverse ruling. Instead, the Plan immediately complied with the district court's mandate and

certified coverage— resulting in Norma Martin's lung being transplanted within six months after her case was first filed. The district court also noted that Martin would not have prevailed but for a procedural irregularity in the Plan's decision-making process.

The district court was faithful to the substantive purpose of ERISA in analyzing the case as it did. While ERISA's purpose is remedial, it was enacted to protect, among other things, "the interests of participants in employee benefit plans and their beneficiaries." 29 U.S.C. § 1001(b). In this instance, the Plan did nothing to hinder the interests of a participant in an employee benefit plan. It denied, as experimental, benefits for a lung transplant. A good faith denial of benefits due to a fair disagreement over the extent to which a prospective procedure is covered by a plan does not necessarily endanger participants in the plan. While it may thwart the particular participant who wishes to receive the procedure, the good faith denial may well better serve the remaining plan participants by keeping costs at a reasonable level. If the factors are to have any force and effect, a plan cannot presumptively be charged with attorney fees every time it is reversed in its decision to deny benefits. *Cf. Fogerty*, 510 U.S. at 533 ("The automatic awarding of attorney's fees to the prevailing party would pretermit the exercise of that discretion."). On the other hand, encouraging a plan to act expeditiously and appropriately once benefits have been ordered will ultimately best promote the "interests of participants in employee benefit plans and their beneficiaries." 29 U.S.C. § 1001(b). A plan that understands it may avoid attorney fees if it acts appropriately and quickly is more likely to do so.

III. CONCLUSION

Finding no abuse of discretion by the district court, the judgment is affirmed.

BYE, Circuit Judge, with whom McMillian, Circuit Judge, joins, concurring in part and dissenting in part.

I agree with the majority's decision to abandon the use of the presumption when considering ERISA attorney fee applications under 29 U.S.C. § 1132(g). I disagree with two other aspects of the majority opinion.

First, the majority re-affirms a district court's use of the five-factor test when deciding whether to award fees to a successful ERISA plaintiff. *Ante* at 8-9. The five-factor test has been criticized as "an unhelpful method for determining the appropriateness of awards to prevailing plaintiffs in ERISA actions." Mark Berlind, *Attorney's Fees under ERISA: When is an Award Appropriate?*, 71 Cornell L. Rev. 1037, 1058 (1986). Criticisms of the five-factor test include (a) the superfluous nature of the first factor, since courts already have the inherent ability to shift fees because of bad faith, (b) the fact that the second factor does not apply to most ERISA situations because an ERISA plan typically pays the fees of a prevailing party rather than the plan administrators *personally*, and (c) ERISA already provides strict fiduciary standards that accomplish the goals of the third factor, deterrence. *See id.* at 1058-61; *see also Cent. States S.E. & S.W. Areas Pension Fund v. Hitchings Trucking, Inc.*, 492 F.Supp. 906, 909 (E.D.Mich.1980) ("[I]t is difficult to determine the relationship of ERISA to each of these factors."). I believe we should develop a better test.

I would abandon the first three factors and replace them with one—"whether a reasonable plaintiff would have brought suit if no award of attorney's fees was possible." 71 Cornell L.Rev. at 1062. In this case, Norma Martin sued to obtain a lung from the Plan, not monetary benefits from which a portion could be used to pay an attorney. In all similar cases where success means the recovery of non-monetary benefits, plaintiffs will have difficulty obtaining legal representation but for the possibility of recovering fees under § 1132(g). If participants who seek non-monetary benefits cannot retain attorneys, ERISA's provisions will not be effectively enforced. Such suits will only be filed, and ERISA's provisions will only be effectively enforced, if success on the merits portends a likely recovery of fees under § 1132(g). In exercising discretion to award fees, a district court should therefore consider whether a suit will result in a monetary recovery from which adequate fees can be paid. If not, fees should probably be awarded under § 1132(g).

Second, in denying fees, the district court noted that Martin would not have prevailed but for a procedural irregularity in the Plan's decision-making process. The majority apparently approves the district court's consideration of that factor in denying fees, *ante* at 9, but I am greatly troubled by this factor because it often leads to the imposition of liability in the first place.

In ERISA cases in which the Plan administrator funds the plan, the conflict triggers a less-deferential standard when "(1) a palpable conflict of interest *or a serious procedural irregularity exist[s]*, which (2) cause[s] a serious breach of

the plan administrator's fiduciary duty." *Woo v. Deluxe Corp.*, 144 F.3d 1157, 1160 (8th Cir. 1998) (emphasis added). In other words, we heighten our review of a Plan's denial of benefits precisely because of procedural irregularities in its decision-making process, and our heightened standard of review is often outcome-determinative. *See Barnhart v. UNUM Life Ins. Co. of Am.*, 179 F.3d 583, 589 (8th Cir. 1999) ("Logically, a plaintiff who can show that a conflict of interest or serious procedural irregularity caused a serious breach of the administrator's fiduciary duty will more than likely have substantial evidence showing that the fiduciary's decision was arbitrary and capricious."). The majority's discussion will have the incongruous effect of justifying a denial of fees when that is the very reason a plaintiff prevails. ERISA plans now have less incentive to avoid procedural blunders because they will not be responsible for paying attorney fees when they occur.

* * *

Because the district court improperly considered the existence of a procedural irregularity as a factor that justified its denial of fees, and in my view gave too little consideration to the fact that Norma Martin's successful suit yielded no monetary benefits from which fees could be paid, I would reverse and remand with instructions to award fees at a reasonable hourly rate.

A true copy.

Attest:

CLERK, U.S. COURT OF APPEALS, EIGHTH CIRCUIT

APPENDIX B — JUDGMENT AND MEMORANDUM OPINION OF THE UNITED STATES DISTRICT COURT FOR THE WESTERN DISTRICT OF ARKANSAS, FAYETTEVILLE DIVISION DATED AND FILED JUNE 6, 2000

IN THE UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF ARKANSAS
FAYETTEVILLE DIVISION

Civil No. 00-5035

NORMA MARTIN and BRIAN MARTIN

PLAINTIFFS

v.

ARKANSAS BLUE CROSS AND BLUE SHIELD,
A MUTUAL INSURANCE COMPANY

DEFENDANT

JUDGMENT AND MEMORANDUM OPINION

Now on this 6 day of June, 2000, the captioned matter comes on for consideration, and the Court, having reviewed the administrative record and the briefs of the parties, finds as follows:

1. *Procedural History*:

Plaintiff Norma Martin suffers from bronchoalveolar cell carcinoma ("BAC") which has resulted in the loss of one

lung, and now threatens her remaining lung. Her treating physicians have recommended that she undergo a lung transplant. Plaintiffs brought suit for declaratory, compensatory and injunctive relief, alleging that defendant had wrongfully failed and refused to certify benefits for the lung transplant pursuant to an employee welfare benefit plan in which Mrs. Martin is a participant. Plaintiffs claim entitlement to compensatory relief on theories of breach of contract and negligent infliction of emotional distress.

Defendant denies that the plan provides coverage for the procedure, and affirmatively pleads that — because the plan is an Employee Benefit Plan pursuant to the Employee Retirement Income Security Act of 1974 ("ERISA"), **29 U.S.C. §1001 et seq.** — plaintiffs' state law claims are pre-empted.

The parties submitted a stipulated administrative record ("the Record"), as well as briefs setting forth their respective positions on the coverage issue. From the briefs it appears that plaintiffs concede that this matter is governed by ERISA, and that their state law claims are pre-empted. They have not briefed their state law claims, and the Court will not address those claims separately, but will deal with the matter solely as an ERISA claim and will address the issue of whether there is coverage under the policy for Mrs. Martin's lung transplant. See, e.g., ***Thompson v. Gencare Health Systems, Inc.*, 202 F. 3d 1072 (8th Cir. 2000).**

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2. *Standard of Review*:

The Managed Benefits Comprehensive Major Medical Preferred Provider Organization Group Benefit Certificate ("the Policy") which defines Mrs. Martin's benefits gives defendant discretionary authority to make benefit decisions: "The Company acting on behalf of the Plan shall have authority and full discretion to determine all questions arising in connection with your insurance benefits, including but not limited to eligibility, interpretation of Plan language, and findings of fact with regard to any such questions." Defendant is therefore an ERISA plan fiduciary. **29 U.S.C. §1002(21)(A)**.

This Court's review of benefit eligibility decisions is limited where a benefit plan gives the fiduciary discretionary authority to make benefit determinations. Such decisions are reviewed for abuse of discretion, although review may be less deferential if a significant conflict of interest or procedural irregularity is shown to have caused a serious breach of the fiduciary's duty. *Woo v. Deluxe Corporation*, **144 F.3d 1157 (8th Cir. 1998).**

Plaintiffs do not contend that defendant labors under a significant conflict of interest, but argue, instead, that the Policy is ambiguous, which "results in de novo review." No authority is cited in support of this proposition, and the Court does not agree with the argument as stated.

The Court does find, however, that a procedural irregularity affects defendant's eligibility review, by virtue of Policy language which states that transplants "are subject to

individual approval based upon criteria established by the Company." The Policy does not set forth the criteria used in making an "individual approval" determination for organ transplants. In Mrs. Martin's case, the Company did not reveal any such criteria until March 22, 2000, although the application for certification was made in December, 1999. When defendant did set forth the criteria, they were only partially stated.[1]

Defendant contends that it simply denied Mrs. Martin's application under another portion of the policy, the experimental/investigational exclusion. The Court does not find this contention supported in the Record. Defendant sent Mrs. Martin's file out for review by two independent physicians. It doing so, it did not solicit opinions about whether the proposed treatment was experimental/investigational, but rather asked whether an exception should be made to company policy excluding coverage for transplantation in the presence of active malignancy. Thus it clearly appears from the Record that an individual determination was made in Mrs. Martin's case.

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1. In a letter dated March 22, 2000, Victoria Charlesworth, Appeals Coordinator for defendant, states that "[t]he Arkansas Blue Cross and Blue Shield coverage policy for lung transplants is based in part on the International Guidelines for the Selection of Lung Transplant Candidates. These guidelines have been published in the following distinguished medical journals: . . . . These guidelines list as a 'contraindication' to lung transplant, any person with 'an active malignancy within the last two years with the exception of basal cell and squamous cell carcinoma of the skin'. 'Contraindication' means that a lung transplant is not recommended as effective in such circumstances. Obviously, Mrs. Martin falls within this excluded category."

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It is also clear from the record that the criteria made known to the Martins — and to the Court — are incomplete. If the criteria set forth in March 22, 2000, letter were the only criteria that applied, the lung transplant would have unquestionably been excluded under the Policy, yet defendant considered covering the procedure.[2]

These facts lead the Court to conclude that there is more to this particular benefit determination than meets the eye — and more than is contained in the Record: an "individual approval" determination in Mrs. Martin's case was made, and it was based on criteria not fully shown in the Record. Because of this procedural irregularity, and its accompanying impact on the eligibility determination, the review accorded the eligibility determination is less deferential than it would otherwise be.

In a deferential review, the proper inquiry is whether the eligibility determination was reasonable, i.e., supported by substantial evidence. A decision is reasonable if "a reasonable person *could* have reached a similar decision, given the evidence before him, not that a reasonable person *would* have reached the decision." ***Cash v. Wal-Mart Group Health Plan*, 107 F.3d 637 (8th Cir. 1997).**

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2. Defendant solicited two independent medical opinions with letters which commenced by informing the reviewer that "[c]urrent policy at Arkansas Blue Cross and Blue Shield does not allow a lung transplant for carcinoma of the lung but this member's situation is unusual and an independent review is requested" and concluded by asking "[s]hould an exception be made in this case to allow lung transplant for a diagnosis of alveolar carcinoma of the lung?"

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Five factors influence the review of a eligibility determination:

(a) Is the interpretation of the Policy consistent with the goals of the Policy?

(b) Does the interpretation render any language in the Policy meaningless or internally inconsistent?

(c) Does the interpretation conflict with the substantive or procedural requirements of ERISA?

(d) Have relevant terms been interpreted consistently?

(e) Is the interpretation contrary to the clear language of the Policy? *Id.*

The abuse of discretion standard is "inherently flexible." In the face of a procedural irregularity, a "sliding scale" approach is appropriate to decrease the degree of deference accorded the administrative decision in proportion to the seriousness of the procedural irregularity. ***Woo v. Deluxe Corp.*, 144 F.3d 1157 (8th Cir. 1998).** While the "sliding scale" approach has not been quantified, decisions analyzing it have described the conflict or procedural irregularity as a factor to be weighed in determining whether the fiduciary acted reasonably. ***Barnhart v. UNUM Life Insurance Company of America*, 179 F.3d 583 (8th Cir. 1999).** The Court will therefore weigh into its evaluation of the reasonableness of defendant's decision the fact that it used criteria not made known to either the Martins — or this Court — in making its decision.

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3. *The Plan Provisions*:

Two different provisions of the Plan are relevant to the issue before the Court. The Plan specifically addresses organ transplants in the following sections:

ARTICLE IV. HOSPITAL BENEFITS

* * *

C. Limitations of Hospital Benefits

* * *

7. Services rendered to you for organ transplants. Such transplants are subject to individual approval based upon criteria established by the Company.

ARTICLE VII. OTHER COVERED MEDICAL EXPENSES

* * *

U. Services rendered to you for organ transplants. Such transplants are subject to individual approval based upon criteria established by the Company.

The above-quoted passages were not specifically made the basis for the administrative decision. Rather, defendant based the denial on Article XIV(H), dealing with experi-

mental or investigational services. That section provides, in relevant part:

ARTICLE XIV. SERVICES NOT INCLUDED

No benefits or services of any kind are provided under this Certificate for:

* * *

H. any experimental or investigational services .... The Company shall have full discretion to determine whether a ... medical treatment is experimental or investigational. Any ... medical treatment may be deemed experimental or investigational, in the Company's discretion, if:

3. reliable Evidence (as defined below) shows that the ... medical treatment or procedure is the subject of on-going phase I, II or III clinical trials or is otherwise under study to determine its ... efficacy, or its efficacy as compared with a standard means of treatment or diagnosis;

4. reliable Evidence (as defined below) shows that the majority opinion among experts, as stated in the published authoritative literature, regarding the ... medical treatment or procedure is that further studies or clinical trials are necessary to determine its ... safety, its efficacy or its

efficacy as compared with a standard means of treatment or diagnosis.

5. reliable evidence (as defined below) shows that a majority opinion among experts, as stated in the published authoritative literature, regarding the . . . medical treatment or procedure neither supports nor denies its use for a particular condition or disease.

* * *

"Reliable Evidence" shall mean only the following sources:

(a) the patient's medical records or other information from the treating Physician(s) or from a consultant(s) regarding the patient's medical history, treatment or condition;

* * *

(d) published reports and articles in the authoritative medical and scientific literature, signed by or published in the name of a recognized medical expert, regarding the . . . treatment or procedure at issue . . . .

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4. *The Administrative Decision*:

While defendant does not overtly rely on the "individual approval" language specifically addressed to organ transplants, the Court has concluded, as set forth in §2, supra, that the denial was based on an "individual approval" approach, rather than on a simple application of the "experimental or investigational" language of the Policy or on a straightforward application of the "lung transplant" policy set forth at page 456 of the Record. In submitting Mrs. Martin's medical records to two independent reviewers, defendant began by noting that "[c]urrent policy at Arkansas Blue Cross and Blue Shield does not allow a lung transplant for carcinoma of the lung," and then asked whether "an exception [should] be made in this case to allow lung transplant for a diagnosis of alveolar carcinoma of the lung?" Neither reviewer was asked for an opinion on whether a lung transplant in Mrs. Martin's circumstances was experimental or investigational. The Court concludes that defendant's intention and approach was to make the benefits determination on an "individual approval" basis.

In making its benefit determination, defendant generated the following information:

One outside reviewer, Dr. Michael L. Grossbard, an oncologist, stated that "[i]t is not clear that lung transplantation offers any advantage over conventional therapy in the treatment of bronchoalveolar carcinoma"; that "data regarding the benefits of this treatment approach are lacking"; and "the use of lung transplant is of unknown benefit in the treatment of bronchoalveolar cell carcinoma."

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The other outside reviewer, a transplant surgeon, stated that a lung transplant in Mrs. Martin's circumstances "is strikingly at variance with accepted practice in the transplantation community," although he admitted that the results of a published study of such treatment ("the Alabama study") "seem to be interpreted by the authors as supporting the use of lung transplantation for treatment of this disease" and that "the opinions of clinicians at different institutions may vary" on the subject.

The Alabama study is the article relied upon by defendant. It reports the results of a study at the University of Alabama of lung transplants for the type of cancer from which Mrs. Martin suffers. After performing and following up on seven lung transplants, the authors concluded that "[l]ung transplantation for broncioloalveolar carcinoma is technically feasible, but recurrence of the original tumor within the donor lungs up to four years after transplantation was common."

In addition to these sources, defendant relied upon several telephone conversations of its medical director with other physicians, the gist of which is that (a) the Alabama study had apparently been abandoned after publication of the article, due to "apparent lack of benefit and the scarcity of available lungs," and (b) that Mrs. Martin would not be considered for transplantation at their centers because of the severe shortage of donor lungs.[3]

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3. While these opinions, contained in the Appeals Coordinator's March 22, 2000, letter, appear to be from reputable physicians, the Court accords less weight to them than to other data in the (Cont'd)

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5. *Plaintiffs' Evidence*:

Plaintiffs show that Mrs. Martin has actually been accepted as a lung transplant candidate by two transplantation centers, Integris Oklahoma Transplantation Institute in Oklahoma City and Ochsner Multi-Organ Transplant Center in New Orleans.[4] Her physician at Integris, Dr. Irvin Paradis, takes the position that "the only long term, therapeutic solution to this malignancy, is a lung transplant. . ." and that Mrs. Martin "should be a candidate for this procedure as soon as possible." Dr. Paradis is not without qualifications to make such a determination. The Court notes that for three years (1995-98) Dr. Paradis chaired a subcommittee to develop guidelines for listing candidates for lung and heart-lung transplantation for the United Network For Organ Sharing ("UNOS"). In addition, as a treating physician Dr. Paradis' opinion as to Mrs. Martin's suitability for transplantation carry more weight that the opinions of the reviewing physicians. See, e.g., ***Donaho v. FMC Corp.*, 74 F.3d 894 (8th Cir. 1996)**.

(Cont'd)
Record, inasmuch as they are the Appeals Coordinator's report of Dr. Adamson's report of the physician's report, and therefore constitute hearsay upon hearsay upon hearsay. Quality, as well as quantity, or evidence may be considered in determining the reasonableness of an administrative decision. *Donaho v. FMC Corp.*, 74 F.3d 894 (8th Cir. 1996).

4. The record also reflects that Mrs. Martin was turned down as a candidate for transplantation by four centers, largely because of a shortage in the supply of lungs available for transplantation.

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While not citing any published studies other than the Alabama study cited by defendant, plaintiffs point out that the Alabama study made no finding that lung transplantation for BAC is experimental or investigational. It simply reported the outcome of seven transplants, including the incidence of recurrence of cancer. Plaintiffs also point out that the authors reported that three patients were disease-free several years after their surgeries, that the recurrence of disease in one patient was clinically suspected but had not been histologically confirmed, and that two of the patients with recurrence had been successfully treated with resection of part of the transplanted lung. The author stated that "[f]or four of seven patients, lung transplantation for stage IV bronchioloalveolar carcinoma limited to the lungs was followed by a lengthy period of disease-free survival."[5] Finally, plaintiffs point to the opinion of Dr. Paradis that "survival was just as good in [the Alabama study] patients who received transplants for BAC as it is for lung transplantation in general."

6. *The Court's Conclusions*:

Having carefully considered all of the information that can be gleaned from the Record, the Court concludes that defendant's eligibility determination in this matter was not reasonable.

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5. Defendant's reviewing transplant surgeon noted that "these results seem to be interpreted by the authors as supporting the use of lung transplantation for treatment of this disease" although he gave as his opinion that "recurrence of a fatal disease in the transplanted organ only confirms the futility and the inappropriateness of this form of therapy. . . ."

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This conclusion takes into consideration the five factors enumerated in *Cash*, as follows:

(a) Is the interpretation of the Policy consistent with the goals of the Plan?

The only goal of the Plan which either party has pointed out is that it is a goal of the Plan to provide "good health coverage." The Court notes that the Plan document in the Record also speaks of "quality healthcare" and is designed so that a participant is "free to select any healthcare provider." Precertification is intended "to facilitate case management." The Court believes that these goals can only be fairly achieved if the criteria used "to facilitate case management" are objective and are fully disclosed to participants, which did not happen in Mrs. Martin's case.

(b) Does the interpretation render any language in the Policy meaningless or internally inconsistent?

Defendant relied upon the "experimental or investigational" language in stating that it was denying benefits to Mrs. Martin, but relied upon the "individual approval" provision in determining whether it would deny those benefits. This approach to benefit eligibility determination is inconsistent.

(c) Does the interpretation conflict with the substantive or procedural requirements of ERISA?

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Inasmuch as there is no way to determine exactly what criteria dictated defendant's benefit eligibility decision, the Court considers that decision to be procedurally flawed under ERISA.

(d) Have relevant terms been interpreted consistently?

See item (b), supra.

(e) Is the interpretation contrary to the clear language of the Plan?

See item (a), supra.

The evidence from consultants in this matter is about evenly balanced between defendant's consultants, who take the position that the operation should not be performed under the circumstances, and Mrs. Martin's physicians, who have actually approved her — after extensive workups — for the operation. Those physicians who consider the operation contraindicated do so, it appears, not because it is experimental or investigational, but largely as a way of apportioning scarce lungs among not-so-scarce transplant candidates. The Court considers it significant that defendant did not ask its consultants whether the procedure is experimental or investigational. The letters to Dr. Grossbard and Dr. Capehart inquire about whether a single or a double transplant is the appropriate procedure, what alternatives to transplantation exist, and whether an exception to "current policy" which "does not allow a lung transplant for carcinoma of the lung" should be made. On a sliding scale of review, the evidence from the consultants tips in favor of plaintiffs.

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The evidence from published literature indicates that transplantation is not "the traditional approach," but again, this appears to be based as much — or more — on the need to distribute scarce donor lungs to those who can make the best use of them as on the success of transplantation for treatment of BAC. Plaintiffs argue persuasively that the Alabama study is favorable to them, not to defendant, and defendant's reviewing transplant surgeon concedes that the Alabama study is interpreted by its authors as yielding favorable results for the treatment.

The Court also notes that defendant's medical reviewers incorrectly refer to the Alabama study as "the only published study" of results of lung transplants for BAC. A "Review Article" included at page 460 of the Record states that "[a]lthough lung cancer has traditionally represented an absolute contraindication to transplantation, successful transplantation for bronchoalveolar carcinoma has been documented," citing a 1997 article in the journal *Chest*. The Record also includes a document from Ochsner entitled Rationale For Considering Patients With Bronchoalveolar Cell Carcinoma, which cites a study of such transplants being done by the Loyola Lung Transplant Team. On a sliding scale of review, the evidence from the published sources also tips in favor of plaintiffs.

The Court concludes that the defendant's administrative decision not to certify Mrs. Martin's lung transplant on the basis of the Policy's experimental /investigational exclusion is not reasonable. Defendant has not shown evidence from consultants or published sources to the effect that the procedure is the subject of study to determine its efficacy as

compared with a standard means of treatment, the method prescribed by XIV.H.3 to establish that a procedure is experimental or investigational. It has not shown that a majority of experts find further studies necessary to determine the safety or efficacy of the procedure, the method prescribed by XIV.H.4 to establish that a procedure is experimental or investigational. Nor has it shown that a majority opinion neither supports nor denies the use of the procedure, as called for in XIV.H.5. These are the applicable criteria in the Plan for a determination that the procedure is experimental or investigational.

In addition, the individual determination of whether to grant or deny coverage for Mrs. Martin's lung transplant was based on criteria not fully shown in the Record. If defendant had truly intended to make the decision based on its experimental/investigational exclusion, the Court believes it would have solicited opinions from its outside consultants about whether the procedure was considered experimental or investigational, instead of soliciting their views on whether it was the appropriate treatment for a particular patient and whether "an exception" should be made for her. If there was an absolute exclusion for lung transplants for carcinoma of the lung, coverage would have been denied without soliciting any outside opinions at all. Were lung cancer the only criteria to be applied in an individual determination, the Appeals Coordinator would not have stated that "coverage policy for lung transplants is based in part on the International Guidelines for the Selection of Lung Transplant Candidates."

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While defendant argues that the "individual approval" language of the Policy "which specifies that Blue Cross likewise has discretion on coverage of organ transplants" is permissible under the current state of ERISA law, the Court does not agree. It is true that a fiduciary may be granted discretion to determine eligibility for benefits under the terms of an insurance policy, but that is a very different matter from being given discretion to determine what the terms of the policy are.

In the case at bar, the Court concludes that the defendant did exercise — and abuse — discretion in determining what the terms of the Policy are. No one but defendant knows the full extent of the criteria that were applied to Mrs. Martin's request for certification of a lung transplant. The Court has searched the Record without success to learn . . . the criteria for certification of a lung transplant — the Record reveals them only part. No document stating those criteria is adduced, but in a letter dated March 22, 2000, to plaintiffs' attorney, defendant's Appeals Coordinator states:

> The Arkansas Blue Cross and Blue Shield coverage policy for lung transplants is based in part on the International Guidelines for the Selection of Lung Transplant Candidates. [citations] These guidelines list as a "contra-indication" to lung transplant, any person with "an active malignancy within the last two years with the exception of basal cell and squamous cell carcinoma of the skin". "Contraindication" means that a lung transplant is not recommended as effective in such circumstances. Obviously, Mrs. Martin falls within this excluded category.

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That this is not a full exposition of the criteria applicable to Mrs. Martin's case is evident not only from the phrase "in part," but also from the fact that her application for pre-certification was not simply denied on the basis of "active malignancy." The Court concludes, from defendant's letters to the outside reviewers, that the approval process for this individual transplant involved factors which have not been made known to either plaintiffs or the Court.

Without knowing the reasons for a decision, it is impossible for the Court to find that it is a reasonable decision, or that a reasonable person would have reached that decision. Where the stated reason for denial of benefits (the "experimental or investigational" exclusion) fails, and the decision-maker does not reveal all the criteria on which it actually based its decision, this Court can only conclude that the decision is flawed, and must, as a result, find that the Policy does in fact provide coverage for the lung transplant sought by Mrs. Martin.

7. For the reasons given, the Court finds that the Policy at issue herein does provide coverage for Mrs. Martin's lung transplant, and that defendant should be required to forthwith certify coverage for this procedure.

IT IS THEREFORE DECLARED that the Managed Benefits Comprehensive Major Medical Preferred Provider Organization Group Benefit Certificate provides coverage for the lung transplant requested by Mrs. Martin.

IT IS FURTHER ORDERED that defendant forthwith certify coverage for the lung transplant requested by Mrs. Martin.

IT IS FURTHER ORDERED that plaintiff submit any desired petition for costs and attorney's fees within fourteen (14) days of the entry of this Order.

IT IS SO ORDERED.

s/ Jimm Larry Hendren
JIMM LARRY HENDREN
UNITED STATES DISTRICT JUDGE

Supreme Court, U.S.
FILED
DEC 10 2002

No. 02-747

IN THE

Supreme Court of the United States

BRIAN MARTIN, Individually and as the Administrator of the Estate of Norma Martin, deceased,

Petitioner,

v.

ARKANSAS BLUE CROSS AND BLUE SHIELD, a Mutual Insurance Company,

Respondent.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

BRIEF IN OPPOSITION

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QUESTION PRESENTED

What should be the standard for resolving applications for attorney fees in cases arising under the Employee Retirement Income Security Act of 1974 ("ERISA")?

Respondent respectfully requests that the Court deny the Petition for Writ of Certiorari. The decision of the lower court brought the Eighth Circuit into line with the majority of the other circuits in establishing the applicable law for ERISA attorney fee applications in the Eighth Circuit. That holding is squarely in accord with the holding in seven of the circuits and does not conflict with any other circuit. There is no Supreme Court precedent on the issue.

STATEMENT OF THE CASE

Norma Martin asked Arkansas Blue Cross and Blue Shield to certify benefits for a lung transplant pursuant to an ERISA employee welfare benefit plan in which she participated. After the plan denied the benefits Martin sued, alleging that benefits had been wrongfully denied.

The district court held that a procedural irregularity rendered the plan's denial unreasonable and ordered the plan to certify coverage for the lung transplant. Martin petitioned for attorney's fees, and asked for a contingent fee based on the cost of the lung transplant surgery. The district court denied the petition for fees, relying upon the five-factor test set forth in *Lawrence v. Westerhaus*, 749 F.2d 494, 495-96 (8th Cir. 1984), and determined that the factors weighed in favor of the plan. The district court acknowledged that *Landro v. Glendenning Motorways, Inc.*, 625 F.2d 1344, 1356 (8th Cir. 1980) created a presumption in favor of awarding fees absent special circumstances, but concluded that consideration of the *Lawrence* factors led the court to deny attorney's fees. Martin filed a Motion for Reconsideration setting forth an hourly fee request. When that petition for reconsideration was denied, Martin brought the appeal to the Eighth Circuit.

In an en banc ruling, the Eighth Circuit reversed *Landro*, and expressly rejected the presumption of attorney's fees for prevailing attorneys in ERISA cases.

REASONS FOR DENYING THE PETITION

Petitioner urges the Court to adopt a presumption in favor of prevailing plaintiffs in all ERISA cases. He suggests that there is an "irreconcilable split" in the decisions of the circuits regarding the presumption. There is actually no split, irreconcilable or otherwise. In fact, no circuit has adopted the position urged by Petitioner.

The First, Third, Fourth, Fifth, Sixth, Eleventh, D.C., and now Eighth circuits have all considered and rejected the presumption urged by Petitioner. *Cottrill v. Sparrow, Johnson & Ursillo, Inc.*, 100 F.3d 220 (1st Cir. 1996); *Eddy v. Colonial Life Ins. Co. of Am.*, 59 F.3d 201 (D.C. Cir. 1995); *Quesinberry v. Life Ins. Co. of N. Am.*, 987 F.2d 1017 (4th Cir. 1993); *Ellison v. Shenango Inc. Pension Bd.*, 956 F.2d 1268, 1274 (3rd Cir. 1992); *Armistead v. Vernitrop Corp.*, 944 F.2d 1287, 1302 (6th Cir. 1991); *Iron Workers Local No. 272 v. Bowen*, 624 F.2d 1255, 1266 (5th Cir. 1980); *Martin v. Blue Cross and Blue Shield*, 299 F.3d 966 (8th Cir. 2002).

The Second and Tenth circuits do not use the presumption, although they have not considered and expressly rejected the presumption. *See Chambless v. Masters, Mates & Pilots Pension Plan*, 815 F.2d 869, 871 (2d Cir. 1987); *Gordon v. United States Steel Corp.*, 724 F.2d 106, 109 (10th Cir. 1983).

It is true that the Seventh and Ninth circuits utilize a presumption in conducting the ERISA attorney's fee application. However, they use the presumption with a version of the five-factor test utilized by other circuits. *McElwaine v. U.S. West, Inc.*, 176 F.3d 1167, 1172 (9th Cir. 1999) and *Little v. Cox's Supermarkets*, 71 F.3d 637, 644 (7th Cir. 1995).

It is important to note that no circuit applies exclusively the presumption urged by Petitioner herein.

Petitioner suggests that *Gonzales v. Transfer Technologies, Inc.*, 301 F.3d 608 (7th Cir. 2002) supports his position that a decision not to appeal is not a sufficient reason to deny attorney's fees. Petitioner suggests that is the only consideration for the denial of fees by the court in the instant case. He is factually wrong in that regard. In the instant case, the court considered the general guidelines which provide direction to the district court but also facilitate a meaningful appellate review. The court acknowledged that Blue Cross and Blue Shield fully cooperated in the review of Mrs. Martin's denial by expediting the exhaustion of plan administrative remedies, by presenting a stipulated record to the district court, by agreeing to a simultaneous briefing schedule, and, finally (but not singularly), by not appealing the district court's adverse ruling. As the court pointed out, the Respondent immediately complied with the district court's mandate and certified coverage resulting in Norma Martin's lung being transplanted within six months after her case was first filed. The court also noted that Martin would not have prevailed but for a procedural irregularity in the plan's decision making process.

Although this Court has not specifically addressed the applicable standard for awarding attorney's fees in ERISA cases, it has construed a similar statute, the Copyright Act's fee-shifting provision, 17 U.S.C. § 505, in *Fogerty v. Fantasy, Inc.*, 510 U.S. 517, 533 (1994). The ruling in *Fogerty* has clear application to the analogous ERISA matters and makes specific review of the ERISA fee-shifting provisions unnecessary.

Finally, Petitioner suggests that failure to adopt a presumption standard will dissuade attorneys from taking ERISA cases. However, Petitioner admitted at the en banc oral argument that few, if any, fee awards have been denied a prevailing plaintiff in ERISA cases nationwide. This is so even though nine of the circuit courts of appeals do not employ any kind of presumption in favor of fees. The Petitioner's fears do not appear founded in fact.

CONCLUSION

Because the decision of the Eighth Circuit Court of Appeals in the case at bar does not conflict with the decision of another United States court of appeals and does not depart from the accepted and usual course of judicial proceedings and does not conflict with relevant decisions of this Court, no certiorari review is warranted.

Respectfully submitted,

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